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To: Commission on Health Care Reform

From: Christine M. Oliver, Deputy Commissioner

Date: December 1, 2006

Re: Cost Shift Task Force Report

Pursuant to Act 191, Section 26, the Department was charged with convening a Cost Shift Task Force to submit recommendations to the Commission on Health Care Reform by December 1, 2006. The charge to the Task Force and its recommendations are included in the following Cost Shift Task Force Report.

I would like to express the Department's sincere appreciation for the hard work and diligence of the members of the Task Force. Each member spent a considerable amount of time contributing their perspective and expertise within severe time constraints.

The issues the Task Force faced are very difficult and fraught with technical considerations. I believe the recommendations included in the report will improve the information available to the Legislature as it wrestles with the issue of financing Health Care Reform.

For additional copies of the report, please contact the Department at 828-2900.

COST SHIFT TASK FORCE REPORT

TO

THE COMMISSION ON HEALTH CARE REFORM

DECEMBER 1, 2006

Table of Contents

The Department of Banking, Insurance, Securities & Health Care Administration would like to thank the members of the Cost Shift Task Force for their generous commitment of time, energy and intellect in preparing this report.

Executive Summary

The Cost Shift Task Force was created by Act 191 to recommend any changes needed to "ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums." The Task Force began its work in October and met several times to discuss critical issues and review the preparation of this report. The recommendations included in this report are being delivered to the Commission on Health Care Reform on December 1, 2006.

The Cost Shift Task Force identified both opportunities and limitations while preparing its report. An opportunity exists to use the Department of Banking, Insurance, Securities & Health Care Administration's (BISHCA's) robust history of community hospital budget reviews to monitor and measure part of the cost shift over time. Over 36% of all Vermont health care expenditures can be measured and quantified through the hospital budget review process. However, this useful cost shift information is limited to hospitals and to physicians employed by hospitals. Cost shift information for other providers is very limited and will require improved and new reporting. The reporting limitations that exist will need to be addressed to improve the scope and accuracy of the cost shift impacts. Also, the Cost Shift Task Force did find considerable limitations in the ability to correlate the relationship of changes in hospital rates to specific changes in insurance premiums.

In addition, the Cost Shift Task Force found there is a limit to how much the cost shift can be reduced by action by the State of Vermont. Medicare reimbursement is controlled at the federal level and the Vermont Medicaid program cannot get federal financial participation to pay more than the upper payment limit established by the Centers for Medicare & Medicaid Services (CMS)[1]. Furthermore, other states' Medicaid programs may reimburse Vermont hospitals at less than cost, creating a cost shift that Vermont cannot impact.

In summary, the limitations found by the Cost Shift Task Force recognize that the science and tools for measuring and monitoring the cost shift currently exist only within the hospital budget review process (it is not clear that regulatory authority exists over other budgets within the health care sector such as pharmaceutical providers, physician practices, home health providers, etc). Thus, this report focuses on how to improve the measurement and reporting for that process and then begin to look at how the science can be extended into the insurance rate review process. More problematic is how to extend efforts to measure the entire cost shift across all providers in the health care system.

[1] The Centers for Medicare and Medicaid Services (CMS) is the federal agency that establishes the payment levels for Medicare services.

The Task Force makes the following recommendations:

1) BISHCA should adopt policies and procedures in the Vermont Community Hospitals Uniform Reporting Manual, to include a definition of and method for measuring the cost shift based on the techniques used in the hospital budget review process.[2]

2) BISHCA should measure hospital rates for each hospital to determine the effect of expense changes related to utilization and inflation, operating margin changes, and cost shift changes related to bad debt and free care, Medicaid, and Medicare.

3) BISHCA should instruct the hospitals to make reporting changes to support information needs relating to bad debt and free care in order to better understand the populations served. This includes the need to distinguish Vermont Medicaid revenues from out-of-state Medicaid revenues.

4) BISHCA should prepare an annual report to the legislature detailing its findings related to the hospital cost shift and the rate effects on hospital and insurance rate increases.

Recommendations that will require more time and analysis include:

5) BISHCA should work with the hospitals to determine whether a standard reporting instrument should be prepared to provide better information about the hospital cost shift.

6) BISHCA should work with stakeholders to examine potential information needs and/or changes for health insurance rate review processes needed to monitor the hospital cost shift.

7) BISHCA should prepare a plan and scope of analysis that seeks to measure the effect of the hospital cost shift on premium rates, once it is determined this can be accomplished reasonably.

8) The "science" to measure the cost shift across non-hospital providers needs to be developed in order to monitor changes in the non-hospital cost shift.

9) Any funds appropriated to alleviate cost shifts should be clearly designated so that their impact on the cost shift could potentially be monitored and measured across the Vermont health care system.

[2] The Vermont Community Hospitals Uniform Reporting Manual provides the budget instructions and reporting requirements for community hospitals as part of the annual hospital budget reviews.

10) A feedback mechanism needs to be developed to report how the funds appropriated to reduce the cost shift were used across the health care system.

BISHCA is prepared to discuss this report further with the Commission on Health Care Reform.

Background

Section 26 of Act 191, An Act Relating to the Health Care Affordability for Vermonters, enacted during the 2006 legislative session, requires that BISHCA convene a cost shift task force that will submit a report to the Legislative Commission on Health Care Reform by December 1, 2006. (The complete text of Section 26 is provided in Appendix B.) The statute dictates three basic points:

1) That four different policy actions should have the effect of reducing the cost shift:
   a. "…increases in Medicaid rates,…"
   b. "…reductions in private insurance claims through the non-group market security trust,…"
   c. "…a decrease in the number of individuals without insurance, and…"
   d. "…the provision of minimum preventive services through Catamount Health…",

2) Describes who should be named to participate on the cost shift task force,

3) Requires that the cost shift task force provide written recommendations by a deadline of December 1, 2006, "... regarding statutory or administrative changes needed to ensure that a reduction in the cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums."

Task Force Assumptions

In discussions during a series of meetings, the Task Force first identified key assumptions:

a) There are information limitations. Therefore, the cost shift focused upon in this report is the cost shift that can be measured through the hospital budget process. This includes both hospital services and hospital employed physician services that are presented in the annual budget reviews.

b) Whatever policy change is made to reduce the cost shift, it is possible to track and monitor reduction in the hospital cost shift and its effect on hospital rates and insurance rates.

c) In order to track and monitor reduction in the hospital cost shift and its effect on hospital rates, it is not necessary to reach consensus on all the

differences in techniques to measure the cost shift, but it is necessary to use one methodology for this process as we measure the changes going forward.

d) Other factors that affect hospital and insurance rates can and need to be measured and monitored in order to place the changes in the cost shift in context and to isolate the changes in the cost shift from other factors.

e) Existing regulatory systems at BISHCA can be used to measure and monitor the hospital cost shift changes, though more analysis needs to be done for the insurance rate review process.

Task Force Approach

The Task Force believes the following approach can be used to ensure that a reduction in the cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums:

1) Clearly define the cost shift and the methodology for measuring the cost shift,

2) Use existing regulatory processes to evaluate, quantify, monitor and report on the cost shift impacts,
   a. Require BISHCA to describe how the hospital cost shift is currently measured,
   b. Have BISHCA describe the hospital cost shift's relationship to hospital and insurance rates, and

3) Have BISHCA calculate the hospital cost shift changes on rates on an annual basis and report those findings.

Defining the Cost Shift

From the perspective of the payer, the cost shift is defined as:

"The payment of higher prices (above cost) paid by one or more payer groups to offset lower prices (below cost) paid by other payers."[3] In layman's terms, this is often referred to as "charging Peter to pay for Paul". From the perspective of a hospital, it is a pricing mechanism used to achieve revenues to support services provided to all patients when payments from some patients (payers) do not cover the costs incurred by those patients.

[3] Health Affairs, Jan/Feb 2006, Volume 25

To measure this, "cost" must also be defined. For the purposes set forth in this report, "cost " is defined as the actual expense of providing care plus a proportional share of the entity's budgeted or projected operating margin.[4] (See Appendix D for more information.)

BISHCA'S Regulatory Processes

What information is currently available?

BISHCA has an annual responsibility to measure Vermont health care expenditures, to forecast that information, and to prepare an annual Unified Health Care Budget. These tasks allow BISHCA to present the cost shift information in a context that can be reported on an ongoing basis.

BISHCA has a history of analyzing the hospital cost shift and has worked with the Joint Fiscal Office (JFO), the Vermont Association for Hospitals and Health Systems (VAHHS), and the Office of Vermont Health Access (OVHA) in examining that information. Each of these parties measures the hospital cost shift using different assumptions. However, all parties acknowledge the cost shift and the various estimates are within a reasonable range and each allows a consistent analysis of the change over time.

BISHCA's methodology for measuring the hospital cost shift by payer is part of the hospital budget review process and has been used since at least 1989. The methodology can be used to evaluate each individual hospital cost shift as well as each payer's component of the cost shift. This information is currently used as part of the evaluation of each individual hospital rate request and approval.

In addition, BISHCA publishes an analysis and reporting of the hospital cost shift as part of the Act 53 reporting requirements. (see www.bishca.state.vt.us/HcaDiv/HRAP_Act53/HRC_BISHCAcomparison_2006/pricing_financial_reports/9_PFreport.pdf)

The Task Force believes that the hospital cost shift can continue to be monitored through two regulatory systems that exist at BISHCA. This includes the annual Hospital Budget Review process and BISHCA's health insurance rate review process. The following describes how the hospital cost shift can be evaluated in the hospital budget review process.

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[4] Consultation with the Vermont's Office of the Auditor of Accounts finds that "Operating margin, or income from operations, represents the net revenue derived from the business of serving patients in a hospital and is generally comprised of the following components:

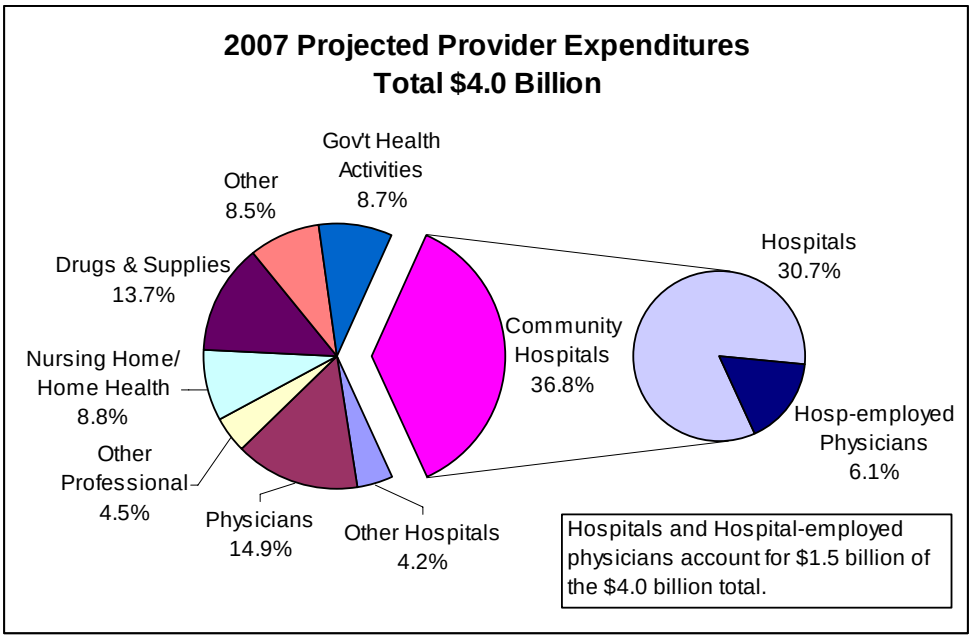
Net patient service revenue less salaries and wages, employee benefits, supplies and contracted services, depreciation and amortization, interest, and other operating expenses equals the operating margin, or income from operations."

Hospital Budget Review Process

Vermont hospitals are required to file a proposed budget for the forthcoming fiscal year that includes financial information, scope-of-service and volume-of-service information, utilization information, proposed new services and programs, capital depreciation and expenditure plans, and any other information the Commissioner may require. (18 V.S.A. § 9454) BISHCA conducts reviews of the submitted hospital budgets along with other information, and the Commissioner establishes a budget for each hospital within which each hospital shall operate. (18 V.S.A. § 9456)

The information submitted by the hospitals in this process contains the information needed to estimate and measure the hospital cost shift. These include expenses, operating margin, gross and net patient revenues by payer (including Medicare, Medicaid, and Commercial), bad debt and free care, and other operating revenue. (See Appendix C for the cost shift calculation methodology and assumptions.)

The most recent annual Unified Health Care Budget draft, for FY 2007, is illustrated below. The chart shows that the community hospital portion of total FY 2007 spending is projected to be $1.479 billion. This includes physicians that the hospitals employ. These dollars represent about 36.8% of the Vermont health care expenditures and are examined as part of the annual hospital budget reviews.



The table below shows a history of the hospital cost shift and reflects how it has changed over the last several years. As the table shows, the cumulative hospital cost shift in FY 2007 is measured at $195 million.

Hospital System
Payers Shifting Costs

	Medicare	Medicaid	Bad Debt & Free Care		Commercial & Other
ACT 01	($32,227,588)	($26,448,350)	($32,706,461)	-------->	$91,382,400
ACT 02	($42,451,009)	($35,667,487)	($33,486,077)	-------->	$111,604,574
ACT 03	($52,076,640)	($34,684,870)	($34,909,000)	-------->	$121,670,510
ACT 04	($55,670,350)	($51,655,330)	($40,878,353)	-------->	$148,204,033
ACT 05	($54,189,891)	($57,226,339)	($40,646,741)	-------->	$152,062,971
BUD 06	($69,505,109)	($66,350,145)	($43,068,440)	-------->	$178,923,693
BUD 07	($66,590,077)	($89,722,282)	($38,853,365)	-------->	$195,165,723
B07-B06 Diff.	$2,915,032	($23,372,137)	$4,215,075	-------->	$16,242,030

Numbers are system totals.
Includes revenues from physicians employed by hospitals.

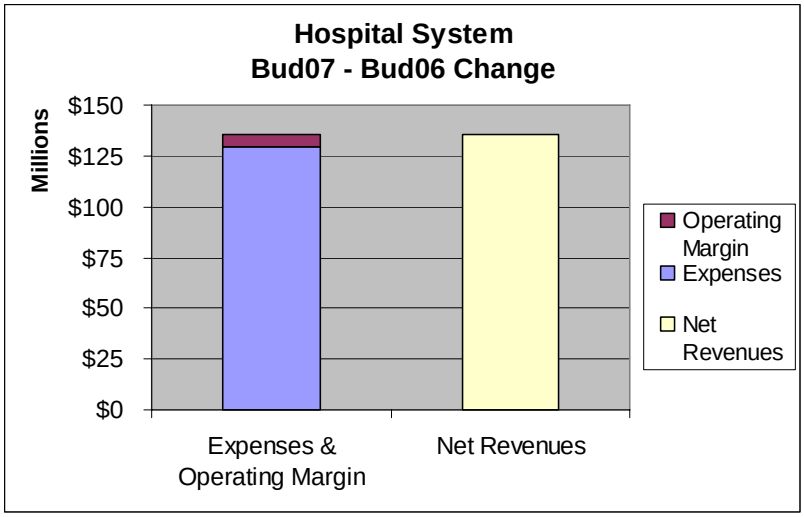
Cost Shift Relationship to Hospital Budget Rate Requests

Hospital budgets are complex and budget changes involve a number of variables. Nevertheless, the review of the budgets and what the budget increases will be buying can be quantified at the individual hospital level. For purposes of illustration, we will describe the cost shift effect of the hospital budget requests in FY 2007.

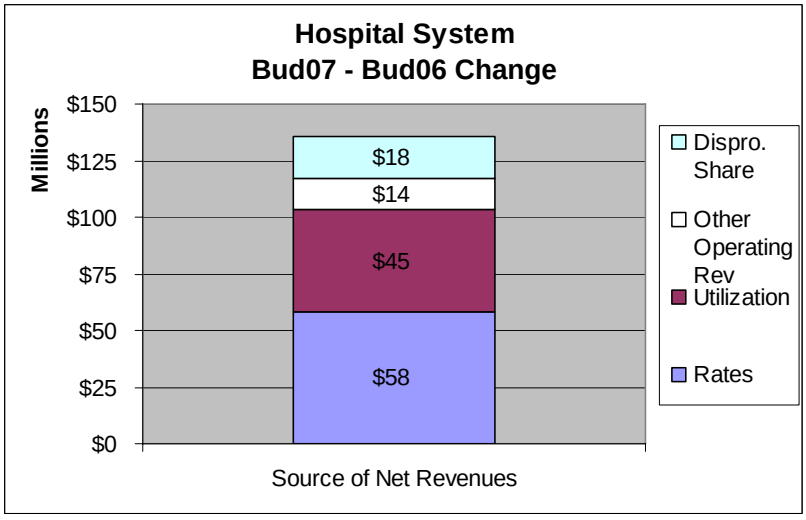
The FY 2007 budgets for the hospitals showed that the hospitals would need an additional $135 million above FY 2006 levels to pay for services and achieve a slightly higher operating margin. Perhaps the most compelling point should be made here – **regardless of whether there was a cost shift or not, the hospitals would still need $135 million more in FY 2007 to pay expenses and operating margin. The change in the cost shift affects *who* pays; it does not affect the total money the hospitals spend. Let us explain:**[5]

[5] The following has been edited by BISHCA to present the cost shift in the context of a given year's budget increase (FY 2007). Certain technical considerations were too complex to present at this time. However, though more precise calculations will actually change some of the values, the overall concept is representative and typical.

From budget 2006 to budget 2007, the total hospital system expense and operating margin increase equals $135 million. A $135 million increase in net revenues[6] is needed to pay for the $135 million increase in expenses and operating margin.



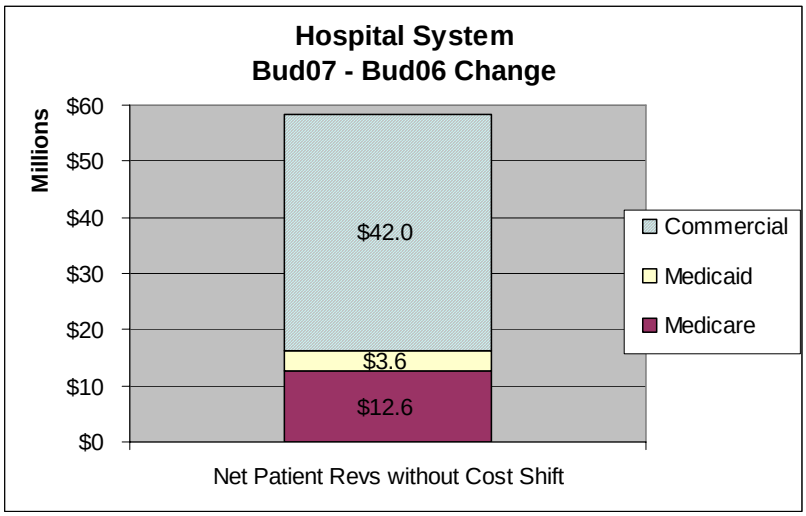
The $135 million increase in net revenues will come from a number of sources: utilization changes (increased use of services based on increased demand), changes in other operating revenue (parking, cafeteria, etc.), a change in Disproportionate Share revenue[7], and an increase in rates charged to the payers.



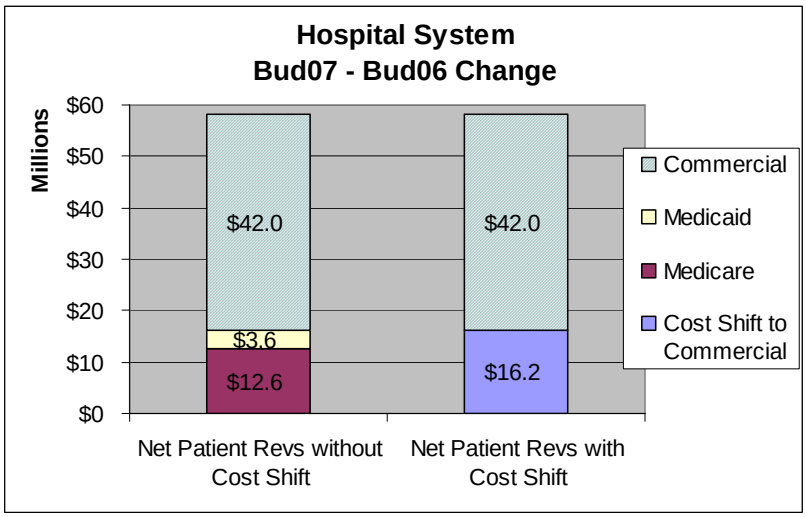
[6] In the world of hospital budgets, "net revenues" does not mean revenues net of expenses, as in the business world. In the hospital budgets, "net revenues" means "revenues net of (after) deductions" such as discounts, write-offs, underpayment, etc. Gross revenue is what is billed; net revenue is what is actually received.

[7] Disproportionate Share is a program administered under Medicaid that provides funding to hospitals based upon the level of their uncompensated care.

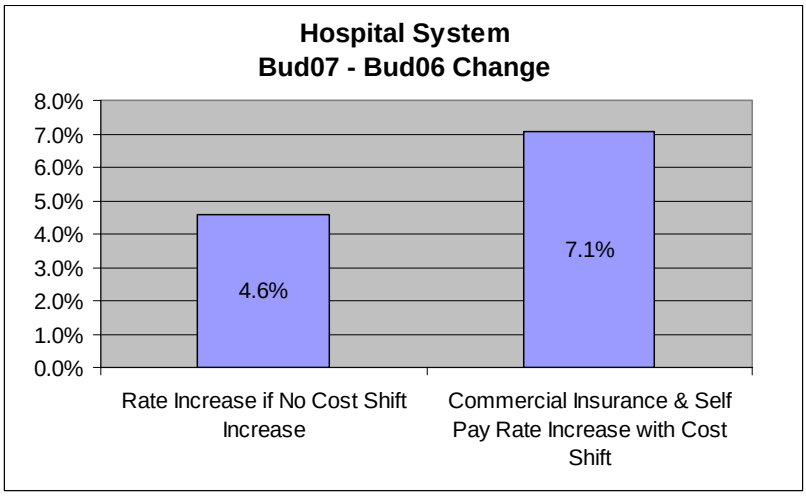
As the previous chart shows, to achieve the $135 million increase in net revenues, $58 million will need to be raised through rate increases. If every payer paid its proportionate share of the net revenue increase, then the $58 million in net patient revenues would come from Medicare, Medicaid, and Commercial insurers, as illustrated below.



But, neither Medicare nor Medicaid usually pay providers based on the providers' charges. Instead, Medicare and Medicaid set their own payment rates, which are completely unaffected by increases in hospitals' charges. The result is that all of the $58 million in additional revenues needed from payers has to come from Commercial carriers – not just the $42 million that is their proportionate share. In other words, government's $16 million share of the increased revenues has to be "cost shifted" to commercial carriers. The commercial carriers will pay the entire increase, not just a proportional share.



For example, if all payers were to pay their proportionate share of the increased revenues, a 4.6% increase in rates would raise the $58 million in net revenues needed by the hospitals. However, because Medicare and Medicaid are unaffected by any increases in rates, the remaining payer, Commercial insurance, has to be charged a higher rate. In this case, that rate is 7.1%.



The cost shift accumulates each year when hospital rates increase, but only commercial payers and self payers foot the bill. As the table on page 10 demonstrates, that cumulative cost shift now equals $195 million. This means that in FY 2007, commercial payers will be paying $195 million more for hospital services than their covered members have incurred for services received.

These charges in excess of actual hospital cost increases paid by commercial insurers show up in the claims filed with those insurers, and will have an impact on insurance rates as described in the next section.

Health Insurance Rate Review Process

Pursuant to 8 V.S.A. § 4062, insurance carriers must submit proposed health insurance premiums for Vermonters to BISHCA for review and approval.

The carriers' actuaries prepare the insurers' rate filings, seeking BISHCA approval of the proposed rates. Included in the rate development are the analyses of actual incurred and paid claims, completion factors, estimated claims outstanding, reinsurance costs, cost trend factors, and other data.

When developing rates, actuaries estimate the "trend", a multiplier intended to predict how much allowed charges will increase over the upcoming policy period. Trend factors are typically developed by analyzing medical, hospital and drug trends separately

and involve an analysis of both unit costs and anticipated utilization. Trends are further adjusted to account for different benefit structures. For example, an actuary may estimate that the "trend" for a typical insurance plan will be 15% above the experience in the current year, based on these and other factors.

In addition to trends, rate development may include a certain amount per contract per month for margin, special fees and discounts, administrative expenses, capitation costs and other expenses to establish a final premium rate for the plan.

BISHCA reviews the filing and ensures that from an actuarial standpoint the rates are not excessive, inadequate or unfairly discriminatory. Rates must also comply with all statutory and regulatory requirements applicable to the carrier and to the type of product at issue. Pursuant to 8 V.S.A. § 4062, the Commissioner disapproves rates that are unjust, unfair, inequitable, misleading or otherwise contrary to the law of the state.

The hospital rate increases approved through the hospital budget process are used by some carriers to predict hospital trend factors, while other carriers use the hospital rates only as a guide when predicting hospital trend factors. Ideally, carriers develop hospital trends based on the carriers' actual past hospital cost experience analyzed over time and in the context of likely future market conditions. It is important to recognize that hospital costs are only a portion of the many factors that go into premium rate development.

Insurance rate development is also impacted by a carrier's negotiations with its participating providers. This additional complication must be considered in developing a model to measure cost shift effects. Differences in payment methodologies, discount amounts, and contract design can all affect the charges from those providers, and thus the premium rates that are established with each plan. The "cost shift" is actually put into effect when the commercial insurers agree to higher rates for providers who include shifted costs from those paying less than cost. Thus, to capture any reduced cost shift, insurers would need to factor into their contract negotiations when providers receive more revenue from government payers. This additional step, among others, must also be considered in developing a model to measure and monitor cost shift effects.

The Task Force understands that the insurance rate review process does not presently allow BISHCA to precisely track the hospital cost shift and its effect on insurance rates. It is evident that hospital costs and claims are included in insurer rate development, but the ability to quantify the specific amount of hospital claims for each plan may require much additional data from the carriers. This will require more time and analysis in order to determine if any reporting changes can provide the necessary information.

Other Research

Maine's Dirigo Plan:

The Task Force reviewed the experience of Maine's Dirigo Health Reform Act. That Act's objectives included a new state-sponsored insurance product to achieve universal coverage, new and improved systems to control health care costs, and initiatives to ensure the highest quality of care statewide. The Act included a funding mechanism that in part was related to expected savings being achieved through a reduction in the cost shift when the uninsured became covered by Dirigo.

Our research has found that both the expectations and certain methodologies in that plan have fallen well short of predictions. Maine does not have a public hospital budget review process as Vermont does, and the law did not include a clear methodology for quantifying either the initial cost shift or reduction of that cost shift. Furthermore, a weakness in the Dirigo model is that only one entity at the very end of the cash stream was charged with quantifying the change in the cost shift. Other entities with influence on the cost shift are not required to quantify the impact of their policy decisions using a standard methodology. Thus, significant disputes, and much legal wrangling, have resulted. BISHCA will continue to monitor the Maine Dirigo health plan to see what more can be learned from their experience.

Vermont's Uncompensated Care & Bad Debt Policy

BISHCA is preparing a report to the Legislature, due January 15, 2007, with recommendations for a uniform uncompensated care and bad debt policy for Vermont's hospitals. Information contained in that report may include monitoring, reporting, or other information that can be applied to BISHCA's review of the cost shift and its impact on hospital and insurance rates.

Current limitations

A number of questions remain around the availability of accurate information, the timeliness of that information, and the lack of consistent reporting processes that can measure cost shift changes across the entire health care system. The Cost Shift Task Force has identified specific limitations below:

1) In most cases, information and reporting systems for non-hospital health care providers (for example, non-hospital-employed physicians, other professionals, and home health care agencies) are not available. If they are available, they may lack clear definitions to measure the cost shift that may affect their part of the health care system.

2) The scope of additional reporting necessary to measure the cost shift for these other health care providers will need to be examined and will require time and regulatory structure changes that are not readily apparent.

3) There is little Vermont information available that measures and describes the number and demographics of people who are using bad debt and free care services.[8]

4) Vermont's current hospital budget reporting does not distinguish between Vermont Medicaid payments and cost shift, and the payments and cost shift created by other states' Medicaid programs when their residents seek care in Vermont. Likewise, the cost shift created in non-Vermont settings when Vermont Medicaid patients seek care outside the state is not quantified. This information would need to be collected and quantified to more accurately measure the cost shift from Vermont Medicaid and Vermont uninsured residents, versus those from other states.

5) Gaining precision in measuring the cost shift at the individual provider level will introduce more reporting requirements than presently exist.

6) The insurance rate review system and the hospital budget review system have different regulatory frameworks and taxonomies (reporting classifications). This makes the direct connection of the hospital rates to the insurance plans difficult and requires more evaluation.

7) Insurance rate filings may require data reporting enhancements in order to allow BISHCA to verify and analyze hospital cost shift effects on premium rates.

8) Insurance rate filings may need to include additional data regarding insureds and providers within the plan network in order to monitor and distinguish between Vermont and out-of-state cost shift impact. Carriers might not routinely collect such data, and requiring collection of this data for reporting purposes may increase administrative expenses for carriers.

9) Changes with Medicaid, the Global Commitment, and Catamount Health will most likely introduce new reporting nuances that will need to be addressed as program development and implementation get underway.

In summary, the limitations found by the Cost Shift Task Force recognize that the science and tools for measuring and monitoring the cost shift currently exist only within the hospital budget review process (it is not clear that regulatory authority exists over other budgets within the health care sector such as pharmaceutical providers, physician practices, home health providers, etc). Thus, this report focuses on how we can better improve the reporting and measuring for that process and then begin to look at how the science can be extended into the insurance rate review process. More problematic is how

[8] BISHCA will be preparing a report by January 15, 2007 to the Senate Committees on Health and Welfare and on Finance and the House Committee on Health Care that will provide the Commissioner's findings and recommendations to establish a statewide uniform uncompensated care and bad debt policy.

to extend efforts to measure the entire cost shift across all providers in the health care system.

Recommendations

The Task Force makes the following recommendations to the Commission on Health Care Reform. At this time it appears that most of these changes can be made through administrative processes and procedures.

1) BISHCA should adopt policies and procedures in the Vermont Community Hospitals Uniform Reporting Manual, to include a definition of and method for measuring the cost shift based on the techniques used in the hospital budget review process.[9]

2) BISHCA should measure hospital rates for each hospital to determine the effect of expense changes related to utilization and inflation, operating margin changes, and cost shift changes related to bad debt and free care, Medicaid, and Medicare.

3) BISHCA should instruct the hospitals to make reporting changes to support information needs relating to bad debt and free care in order to better understand the populations served. This includes the need to distinguish Vermont Medicaid revenues from out-of-state Medicaid revenues.

4) BISHCA should prepare an annual report to the legislature detailing its findings related to the hospital cost shift and the rate effects on hospital and insurance rate increases.

Recommendations that will require more time and analysis include:

5) BISHCA should work with the hospitals to determine whether a standard reporting instrument should be prepared to provide better information about the hospital cost shift.

6) BISHCA should work with stakeholders to examine potential information needs and/or changes for health insurance rate review processes needed to monitor the hospital cost shift.

7) BISHCA should prepare a plan and scope of analysis that seeks to measure the effect of the hospital cost shift on premium rates, once it is determined this can be accomplished reasonably.

[9] The Vermont Community Hospitals Uniform Reporting Manual provides the budget instructions and reporting requirements for community hospitals as part of the annual hospital budget reviews.

8) The "science" to measure the cost shift across non-hospital providers needs to be developed in order to monitor changes in the non-hospital cost shift.

9) Any funds appropriated to alleviate cost shifts should be clearly designated so that their impact on the cost shift could potentially be monitored and measured across the Vermont health care system.

10) A feedback mechanism needs to be developed to report how the funds appropriated to reduce the cost shift were used across the health care system.

Appendices

A. Act 191 Cost Shift Task Force Members

B. Act 191 Cost Shift Legislation – 2006

C. Hospital Cost Shift Calculation Methodology

D. Discussion of Need for Operating Margin

E. Article – "Maine's Dirigo Health Reform Act – Is It Working?"

F. Old Vermont Cost Shift Legislation

G. Flow of Dollars from Hospitals to Commercial Plans

Appendix A

ACT 191 COST SHIFT TASK FORCE MEMBERS

Michael Del Trecco
Vice President, Finance
Vermont Association of Hospitals and Health Systems
Health Care Provider Representative

Jeanne Keller
Keller & Fuller, Inc.
Health Care Consultant,
Business Resource Services
Employer Offering Health Insurance Representative

Paul Harrington
Executive Vice President
Vermont Medical Society
Health Care Professional Representative

Stephen Moss
Chief Financial Officer & Treasurer
Central Vermont Medical Center
Health Care Provider Representative

John Dick
Director of Reimbursement
Office of Vermont Health Access
Office of Vermont Health Access Representative

Steve Kappel
Associate Fiscal Officer, Health Care Finance
Joint Fiscal Office
Interested Party Representative

Leigh Tofferi
Director, Government, Public and Community Relations
Blue Cross Blue Shield of Vermont
Insurer Representative

Gregory Peters
Managing Partner
Lake Champlain Capital Management, LLC
Consumer Representative

Nancy Clermont
Deputy Director
Office of Vermont Health Access
Office of Vermont Health Access Representative

Thomas Frank
Director, Budget and Business Analysis
Fletcher Allen Health Care
Health Care Provider Representative

Timothy Keefe
Deputy Auditor of Accounts
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Michael Davis
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Rebecca Heintz
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Banking, Insurance, Securities and Health Care Administration Representative

Andrea Grishman
Secretary
Health Care Administration
Banking, Insurance, Securities and Health Care Administration Representative

Appendix B

ACT 191 COST SHIFT LEGISLATION – 2006

Sec. 26. COST SHIFT TASK FORCE

Increases in Medicaid rates, reductions in private insurance claims through the nongroup market security trust, a decrease in the number of individuals without insurance, and the provision of minimum preventive services through Catamount Health should reduce the cost shift. The department of banking, insurance, securities, and health care administration shall convene a task force of health care professionals, insurers, hospitals, employers offering private health insurance, the state auditor or designee, a representative of the office of Vermont health access, and other interested parties to determine how to ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums. The task force shall make written recommendations to the commission on health care reform no later than December 1, 2006 regarding statutory or administrative changes needed to ensure that a reduction in the cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums.

Appendix C

HOSPITAL COST SHIFT CALCULATION METHODOLOGY

Division of Health Care Administration
November 2006

Background:

This has been prepared by the Division of Health Care Administration to document the calculation methodology of the "cost shift" in Vermont hospitals. The basic methodology was originally developed by the Vermont Hospital Data Council and Blue Cross/Blue Shield and is now used by the Division. The methodology has changed slightly over time due to better reporting through the hospital budget process.

Methodology:

Revenues:

1. The distribution of hospital gross patient revenues is reported by payer: Commercial insurance, Medicare, Medicaid, and Bad Debt/Free Care (BD/FC). BD/FC is considered a payer though their actual payments are nil.
2. Hospital-employed physician gross patient revenues, by payer, are added to the hospital gross revenues for each payer.
3. Deductions from gross revenue for each payer are deducted resulting in the net patient revenue for each payer. Disproportionate share payments are not included and are eliminated from consideration.
4. Other operating revenues are then distributed, allocated to the payers by the gross revenue percentage distribution of each payer.
5. The result is the total net revenues that each payer contributes for the total services (gross revenues) that have been billed (the net revenue amount also includes the other operating revenue).

Expenses:

6. Total operating expenses less the Provider Tax (a tax levied on hospital revenues) are then allocated by payer by the gross revenue percentage distribution.
7. The calculated total operating margin (revenue calculation total minus expense calculation total) is allocated by payer by the gross revenue percentage distribution.
8. This distributed operating margin by payer is added to operating expenses by payer.
9. This result is the total cost that each payer is considered responsible – their share of expenses and operating margin.

Cost Shift calculation:

10. Expenses for each payer are then subtracted from the net revenues for each payer. If the result is less than zero, then that payer has a shifted cost to another payer. If the revenues less expenses are greater than zero, then that payer contributes to offset the cost shift.
11. The total of the revenues minus expenses across all payers equals zero, with some payers cost shifting and some payers offsetting the cost shift.

Assumptions:

1. All patients contribute equally to the cost of providing care. For example, costs for a Medicare patient are assumed to be the same as a Medicaid patient for similar services.
2. Other operating revenues are allocated on a relative basis, i.e.; if a payers has 10% of the gross revenues, then they are allocated 10% of the other operating revenues.
3. Likewise, all payers are considered to contribute to the operating surplus on a relative basis, i.e.; if a payer has 10% of the gross revenues, then they pay for 10% of the surplus.
4. There has been no adjustment for Medicaid payments being received from other states. This analysis assumes all Medicaid payments and charges are Vermont Medicaid since out of state information is not presently available.
5. Medicaid reported dollars in the hospital budgets are accrued, not paid dollars.
6. No adjustment for patient severity has been applied.
7. Disproportionate Share revenues and Provider Tax expenses are not included in the methodology.
8. Non-operating funds that are part of the Total Margin are not included in the analysis.

VERMONT COMMUNITY HOSPITAL TOTALS
COST SHIFT ANALYSIS
BUDGET 2007 AS SUBMITTED

	Total BUD 07	Medicare	Medicaid	Commercial & Other	Bad Debt & Free Care
Hospital Gross Patient Revenue	$2,000,851,115	$798,532,697	$291,408,683	$839,860,207	$71,049,527
Physician Patient Revenue	$542,765,799	$160,217,917	$76,289,686	$306,258,196	$0
Total Gross Patient Revenue	$2,543,616,914	$958,750,614	$367,698,369	$1,146,118,402	$71,049,527
Gross Percent of Total	**100.00%**	**37.69%**	**14.46%**	**45.06%**	**2.79%**
Hospital Deductions	($855,088,443)	($395,851,929)	($202,064,486)	($186,122,499)	($71,049,527)
Physician Deductions	($297,554,044)	($105,196,924)	($54,280,670)	($138,076,450)	$0
Disproportionate Share Revenue	$56,068,555		$56,068,555		
Total Deductions	($1,096,573,932)	($501,048,853)	($200,276,602)	($324,198,949)	($71,049,527)
Net Patient Revenue	$1,447,042,982	$457,701,761	$167,421,767	$821,919,453	$0
Deduct Disproportionate Share	($56,068,555)		($56,068,555)		
Net Patient Rev w/o DSH	$1,390,974,427	$457,701,761	$111,353,212	$821,919,453	$0
Other Operating Revenue (spread by gross % above)	$32,849,410	$12,381,736	$4,748,622	$14,801,487	$917,565
Total Net Revenue	**$1,423,823,837**	**$470,083,497**	**$116,101,834**	**$836,720,941**	**$917,565**
Operating Expenses (spread by gross % above)	$1,380,619,102	$520,388,666	$199,578,557	$622,087,765	$38,564,115
Provider Tax (spread by gross % above)	$60,415,974	$22,772,239	$8,733,569	$27,222,597	$1,687,568
Total Operating Expenses	$1,441,035,076	$543,160,905	$208,312,126	$649,310,362	$40,251,683
Deduct Provider Tax (spread by gross % above)	($60,415,974)	($22,772,239)	($8,733,569)	($27,222,597)	($1,687,568)
Operating Expenses w/o Prov Tax (spread by gross % above)	**$1,380,619,102**	**$520,388,666**	**$199,578,557**	**$622,087,765**	**$38,564,115**
Net Revenues over Expenses (same as operating margin)	$43,204,735	($50,305,169)	($83,476,722)	$214,633,176	($37,646,549)
Gain (Loss) if all Payers shared the margin equally on basis of gross revenues	$43,204,735	$16,284,908	$6,245,559	$19,467,453	$1,206,815
Expenses by Payer	$1,380,619,102	$520,388,666	$199,578,557	$622,087,765	$38,564,115
Expenses with distributed margin	$1,423,823,837	$536,673,573	$205,824,116	$641,555,217	$39,770,930
Net Revenue	$1,423,823,837	$470,083,497	$116,101,834	$836,720,941	$917,565
Total Cost Shift	**$0**	**($66,590,077)**	**($89,722,282)**	**$195,165,723**	**($38,853,365)**
Relationship to $1.00	**$1.00**	**$0.88**	**$0.56**	**$1.30**	**$0.02**

Appendix D

Discussion of Need for Operating Margin

One of the task force findings was to recognize the need for an operating margin as an integral part of any going concern's operations. Thus it can be viewed as a cost of doing business. Indeed, both the budget review process and the insurance rate process examine the operating margins of the filing entities to evaluate their reasonableness as part of the rate requests.

The Vermont Auditor of Accounts confirms the importance of the operating margin:

> "An operating margin is an important economic consideration because it is representative of the return on invested capital required by an investor to enter, or remain in, a particular line of business, including healthcare. If a provider concludes that it will be unable to achieve its needed return on investment, it is likely to exit the business, or the particular market area that may be less profitable than desired. The desired return on investment varies among providers and is dependent on a number of factors, including whether the investor is a for-profit or non-profit entity, or a quasi-public entity. Nevertheless, an operating margin is needed for any entity in order to provide for capital acquisition and operating cash."

Another perspective is provided by Dr. Louis C. Gapenski at the University of Florida, when he states, "Although for profit and not for profit corporations are fundamentally different, day-to-day financial decisions within the two types of businesses are likely to have a common goal: to maintain the financial viability of the enterprise."[10]

Yet another finding states "The legal distinction between not-for-profit and investor-owned hospitals does not refer to the earning of profits… All organizations not heavily subsidized must earn a profit if they are to survive."[11]

[10] Financial Analysis and Decision Making for Healthcare Organizations, Gapenski, Louis C., 1996
[11] Health Affairs, Sloan and Vraciu, "Investor-owned and Not-for-profit hospitals: Addressing some Issues", 1983

Appendix E

Maine's Dirigo Health Reform Act - Is it Working?

By D. Michael Frink, Esq. and George M. Linge, Esq.

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As reported in the winter 2004 issue of this journal,[1] in 2003 the Maine Legislature enacted An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs.[2] Commonly referred to as the "Dirigo Health Reform Act" (hereinafter the "Act"), this ambitious law, proposed by Governor John Baldacci, has been touted as a comprehensive, system-wide strategy to improve Maine's health care system. The Act includes three inter-related approaches: a new state-sponsored health insurance product ("Dirigo Choice") to achieve universal access to coverage; new and improved systems to control health care costs; and initiatives to ensure the highest quality of care statewide.[3]

Our previous article focused on the expansion of access to health coverage through the voluntary, market-based offering of the Dirigo Choice insurance product. This new product is made available to the previously uninsured through premium subsidies funded by a "savings offset payment" ("SOP") paid by insurance carriers, self-funded plans and third-party administrators. The increases in enrollment in this new subsidized product, coupled with expansions in state Medicaid eligibility, are in theory intended to produce savings by reducing the amount of cost shifting in Maine to the insured and self-insured market. Thus, the "savings" from reduced cost shifting are to be "offset" by "payments" by those that pay for insurance coverage already. The law provides that the SOP cannot exceed these savings, so theoretically policy premiums (even with the SOP assessment) do not increase beyond what they otherwise would have been but for the Dirigo program.

In judging the success of this new program, three fundamental questions were identified in the previous article as being of great concern to the insurance industry, and to the employers in Maine, both large and small, that provide coverage through fully-insured and self-funded plans:[4] 1) Will the product succeed in the marketplace? 2) Are there any real savings to insurers and other payors from the offering of Dirigo Choice? and 3) Will the Dirigo Choice product and the overall Dirigo reforms contain healthcare costs?

Now, after eighteen months of experience with this program, we are beginning to see more clearly how the Dirigo experiment is working. We also are seeing more activity in other states that are moving to enact similar reforms.[5] It appears that, however laudable the goals of the Dirigo Health Reform Act, the actual enrollment in Dirigo Choice has been much less than projected, thereby having a much less than

anticipated effect on reducing the amount of cost-shifting.[6] Insurers and self-funded plans have reported no significant reduction in medical cost trends since the Dirigo programs took effect.[7] These facts raise serious questions about the effectiveness of the Dirigo model, which contains only voluntary limits on healthcare spending by providers.[8] Finally, the SOP-based funding mechanism for the premium subsidies to expand access to coverage has proven to be fundamentally flawed and unsustainable, and must be replaced with a broader-based approach.

At the heart of the Dirigo reforms is the tenet that by reducing the number of uninsured people through the offering of a subsidized insurance product and by expanding state Medicaid eligibility, hospitals and physicians will experience less bad debt and charity care, and will accordingly reduce the extent of cost-shifting to the insured and self-funded market. In Maine, with nearly 50% of those with coverage being covered under Medicare and Medicaid, the degree of cost shifting is among the highest in the nation, driving insurance premiums to levels significantly higher than other, more densely populated states. Thus in theory, the Dirigo reforms attack the heart of the problem. In practice, however, with enrollment in Dirigo Choice lagging far behind projections, there simply is no credible evidence that significant reductions in cost shifting or medical cost trends have yet occurred in Maine. Moreover, as discussed below, insurers and employers have challenged the validity of portions of the Act itself and how it has been interpreted by the Dirigo Health Agency Board in calculating the "Aggregate Measurable Cost Savings" ("AMCS")[9] supposedly produced by that Agency. (These are the "savings" that fund the savings offset payments to Dirigo.) A key part of this challenge includes the way that these alleged savings are counted to determine the amount of the "savings offset payment."

The Dirigo Act established a complex, three-part process for determining the amount of AMCS attributable to the operations of Dirigo Health and the expansion of Medicaid eligibility. First the Board of the Dirigo Health Agency, which is the agency responsible for offering the Dirigo Choice insurance product and overseeing the Maine Quality Forum, is charged under the Dirigo Act with the responsibility for determining each year the amount of AMCS. This determination then goes to the Maine Superintendent of Insurance, who conducts a hearing to review the determination to ensure it is reasonably supported by the evidence. The Superintendent's decision then goes back to the Board for an assessment of a "savings offset payment" ("SOP"), which cannot exceed the amount of the AMCS (as set by the Superintendent of Insurance), or 4% of paid claims, whichever is less.[10]

As has been argued in various phases of the ongoing litigation relating to this three-step process, the DHA Board has an inherent conflict of interest in determining the amount of AMCS, as it relates directly to the amount of funding DHA may collect to support its programs. This situation has been exacerbated by the lack of clear standards in the Act for determining what initiatives are to be included in the AMCS calculation and how the savings produced by each such measure is to be

calculated.[11] DHA itself provided a vivid demonstration of the potential for over-reaching in its initial attempt to claim $250 million in savings in the first year of Dirigo's operations. The Superintendent reduced this figure to $43.7 million, but expressly declined to engage in any legal interpretation of the Act. He therefore did not consider the claims of various litigants that the Board had improperly included various categories of savings that did not relate to the "operations of Dirigo Health," such as enhanced payments to providers under Medicaid, discussed below. The Superintendent also did not control for other factors that influence savings, such as national cost trends, patient volume and regularly occurring variations in costs for healthcare providers.[12] The Superintendent's decision also did not fully review and analyze the reasonableness of DHA's assumption that hospital and physician providers, which have been long overdue for increased and more timely Medicaid reimbursement, would pass on to payors the full amount of the alleged savings created by enhanced Medicaid payments to them, even if those were assumed to be the result of the "operations of Dirigo Health."[13]

The Maine Association of Health Plans and its member companies, as well as the Maine State Chamber of Commerce, representing large Maine employers with fully-insured and self-funded health plans, have been engaged in litigation to challenge the constitutionality of the Act itself (on vagueness grounds and as an improper delegation of the taxing authority of the Legislature) and the Board's and the Superintendent's decisions on the methodology and calculation of AMCS and the SOP. Given the possible precedent that may be created in these cases, this issue has drawn careful scrutiny by the health insurance industry's national association, America's Health Insurance Plans. The outcome of the litigation remains uncertain, and at this time there are ongoing legislative negotiations to attempt to replace the AMCS/SOP with another funding mechanism.

Regardless of the outcome of the litigation and the legislative negotiations, however, several key lessons can be learned from the "Dirigo experiment." First, reducing bad debt and charity care (and associated cost-shifting) through expanded coverage to the previously uninsured and expanded Medicaid eligibility can work, but the net impact of such efforts on medical cost trends that drive the prices paid by insured and self-funded plans has yet to be significant. In fact, it appears that the actual savings will never be sufficient to form the sole basis for funding such programs through "savings offset payments."

Second, the Dirigo Board has not developed a credible and sustainable methodology for determining AMCS and the SOP. In fact, as suggested above, it is probably not feasible to develop such a methodology that would provide a long-term basis for funding this program at the level needed for the Baldacci Administration to achieve the goals it has set. The result is an ongoing lack of support and continued legal challenges from the health plans, major employers and other payors in Maine. The prospects for a legislative resolution are complicated by the fact that the debate has continued into a gubernatorial election year. Governor Baldacci has embraced this program as a centerpiece of his administration's priorities since the enactment of the

Act, making it a critical factor in his re-election campaign.

A legislative resolution has been further complicated by a bill, under active consideration, that would prohibit insurers from passing the SOP through to policyholders.[14]

As laudable as the goals and original intent of the Dirigo health reforms may be, it is a flawed approach which should be modified in several key respects, as other states appear to have recognized. First, the funding for increased insurance and Medicaid coverage must be as broad-based as possible, and the methodology must be fair and transparent. Those with insurance and those companies that provide coverage through fully-insured or self-funded plans should not be paying for the expansion of coverage for the uninsured. The employers that do not provide coverage for their employees should be assessed instead, as is the case in Maryland and in a plan recently adopted by the Legislature in Massachusetts.[15] Further, increased general fund appropriations are needed for Medicaid expansions and to supplement employer contributions for subsidies.

Second, a mandate for coverage for both individuals and employers is probably needed, subject to income and affordability/subsidy guidelines, although this element will likely involve complex governmental oversight, guidelines and regulation.[16]

Third, even with these additional reforms, it will be difficult to achieve significant reductions in medical cost trends absent meaningful controls on hospital prices. Maine hospitals correctly point out that Maine's high percentage of Medicare and Medicaid patients (for whom the federal and state governments pay only a portion of the cost of care) produces an abnormally high cost shift. A state statutory requirement that Maine hospitals, all of which are not-for-profit institutions, must provide care to every person regardless of ability to pay also serves to exacerbate an already unfavorable situation. Expanding insurance coverage is therefore a good starting point, but it is not likely to address the crippling cost of coverage and health care generally until a mixture of price controls and higher governmental reimbursement levels can be included in the equation.

One thing is certain. Maine will continue to struggle to achieve the ambitious goals of the Dirigo Health Reform Act. To lead on this issue, true to the State's motto (Dirigo means "I lead" in Latin), Maine will need to consider what certain other states are doing and adopt some of those ideas in order to develop a more credible and sustainable approach for funding healthcare reform.

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[1] FORC Quarterly Journal of Insurance Law and Regulation, vol. XV, Edition VII.
[2] The insurance code provisions of the Dirigo Health Reform Act are codified at 24-A M.R.S.A. ch. 87, §§ 6901-6971 (Supp. 2005). The Act was originally enacted as Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law

2005, ch. 400 (effective Sept. 17, 2005).
[3] The Act also amended three other titles in the Maine Revised Statutes, in addition to the major revisions to the Maine Insurance Code, including the statutes regulating public health and welfare, Title 22. Part A established the Maine Quality Forum, to collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best-practices. 24-A M.R.S.A. § 6951-52. Part B established a capital investment fund to limit the amount of new capital expenditures by hospital and non-hospital providers. 22 M.R.S.A. § 101-05. Part F, an unallocated and non-codified part of the Act, established voluntary limits on hospital cost and on insurance companies underwriting gains for one year.
[4]These questions were identified in interviews with representatives of the Maine State Chamber of Commerce and the National Federation of Business. These organizations taken together represent over 10,000 Maine business, both large and small.
[5] The Maryland law entitled the "Fair Share Health Care Fund Act" is set to take effect January 1, 2007. Chapter 3 of the Acts of the General Assembly of 2006. The Massachusetts law entitled the "Health Care Access and Affordability Act" took effect on April 12, 2006. Chapter 58 of the Acts of 2006.
[6] Based on reports from the Dirigo Health Agency, total enrollment was by now to approach 30,000, when in fact only approximately 7,500 people have enrolled.
[7] Actuaries and network contracting and marketing representatives from several insurance companies including Anthem Blue Cross Blue Shield, CIGNA and Aetna have appeared as witnesses in the first year AMCS proceedings before the Superintendent of Insurance. All concur that no significant reduction in medical cost trend has been experienced in Maine as a result of the Dirigo Health Reforms.
[8] See Dirigo Health Reform Act, Part F, supra.
[9] See note 11 below for the statutory definition of AMCS.
[10] 24-A M.R.S.A. § 6913(1-3).
[11] The only guidance in the Act as to what constitutes AMCS and how it is to be calculated is contained in the following provision: "After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6913(1)(A).
[12] The full text of the Superintendent's decision can be viewed at www.state.me.us/pfr/ins/ins05700dirigo.htm
[13] Id.
[14] Legislative Document 1935, "An Act to Protect Health Insurance Consumers."
[15] Chapter 3 of the Acts of the General Assembly of 2006; Chapter 58 of the Acts of 2006.
[16] The Massachusetts law as passed by both houses contains both of these mandates. Chapter 58 of the Acts of 2006.

Appendix F

OLD VERMONT COST SHIFT LEGISLATION

The 2000 General Assembly included the following reporting requirements, and an allocation to help offset the cost shift, in that year's budget act, Act 152. Note that this section was repealed in 2002 with the passage of Act 63 (also reprinted below):

Sec. 117b. MEDICAID COST SHIFT REPORTING

(a) It is the intent of this section to measure the elimination of the Medicaid cost shift. For hospitals, this measurement shall be based on a comparison of the difference between Medicaid and Medicare reimbursement rates. For other health care providers, an appropriate measurement shall be developed that includes an examination of the Medicare rates for providers. In order to achieve the intent of this section, it is necessary to establish a reporting and tracking mechanism to obtain the facts and information necessary to quantify the Medicaid cost shift, to evaluate solutions for reducing the effect of the Medicaid cost shift in the commercial insurance market, to ensure that any reduction in the cost shift is passed on to the commercial insurance market, to assess the impact of such reductions on the financial health of the health care delivery system, and to do so within a sustainable utilization growth rate in the Medicaid program.

(b) By December 15, 2000, and annually thereafter, the commissioner of banking, insurance, securities, and health care administration, the secretary of human services, and each acute care hospital shall file with the joint fiscal committee, in the manner required by the committee, such information as is necessary to carry out the purposes of this section. Such information shall pertain to the provider delivery system to the extent it is available.

(c) By December 15, 2000, and annually thereafter, the report of hospitals to the joint fiscal committee under subsection (b) of this section shall include information on how they will manage utilization in order to assist the agency of human services in developing sustainable utilization growth in the Medicaid program.

(d) By December 15, 2000, the commissioner of banking, insurance, securities, and health care administration shall report to the joint fiscal committee with recommendations on mechanisms to assure that appropriations intended to address the Medicaid cost shift will result in benefits to commercial insurance premium payers in the form of lower premiums than they otherwise would be charged.

(e) The first $250,000.00 resulting from declines in caseload and utilization related to hospital costs, as determined by the commissioner of social welfare, from the funds allocated within the Medicaid program appropriation for hospital costs in fiscal year 2001 shall be reserved for cost shift reduction for hospitals. **The 2002 General Assembly**

included the following reporting requirements in that year's budget act, Act 63. This section repealed Sec. 117b in Act 152 (2000) noted above:.

Sec. 123a. EQUITABLE MEDICAID REIMBURSEMENT AND THE MEDICAID FISCAL DEFICIT

The General Assembly finds that:

1) While Vermont has been a leader in expanding access to health care coverage through its Medicaid programs (including traditional Medicaid, the Dr. Dynasaur program, the Vermont Health Access Plan, VHAP-Pharmacy and VScript), and has a high quality and low cost health care system as recognized by federal measurement, Vermont has not adopted fiscal policies adequate to sustain program costs.

(2) The Vermont Medicaid program is part of the larger health care cost escalation landscape, where Vermont and the nation are experiencing a crisis in health care affordability affecting businesses large and small, state employee and teacher benefit plan costs, as well as the cost of the Medicaid program.

(3) Expenditure growth in Vermont's Medicaid program is particularly acute because of increased enrollments following program expansions, and because of rising prescription drug costs that affect the traditional Medicaid program and program expansions such as VHAP-Pharmacy and VScript.

(4) Medicaid costs paid by the state are substantially higher than they otherwise would be if enhanced federal financial participation (e.g. SCHIP) were available for more of Vermont's programs.

(5) Vermont's fiscal options for Medicaid programs are further limited, absent a federal waiver, by federal Medicaid rules that do not permit significant cost sharing by most program beneficiaries, and by federal Medicaid rules that mandate a specific, comprehensive health benefit coverage.

(6) The federal Medicaid financial participation rate does not reward Vermont's achievement as a relatively low cost, high quality health care system, since federal financial participation is based solely on per capita income, rather than on the performance of our health care system.

(7) Vermont Medicaid program reimbursement generally is lower than reimbursement paid by commercial insurers, by self insured plans, and by the Medicare program. The Vermont Medicaid program generally does not provide revenue adequate to recover the estimated cost of service.

(8) Cost shifting occurs in the health care financing system when different purchasers pay different amounts for the same service. Medicaid cost shifting occurs when hospitals and some large physician groups are paid by non-Medicaid payers for part of the costs incurred in providing services to Medicaid beneficiaries. Many physicians and other health care providers are unable to shift the cost of providing Medicaid services to other payers.

(9) Medicaid is not the only health benefit plan whose reimbursement policies result in cost shifting: for example, hospitals shift costs incurred in providing Medicare services to other health benefit plans; many health benefit plans secure steep discounts from retail pharmacies that result in higher costs for uninsured individuals; and the cost of hospital free care is recovered from public and private health benefit plans.

(10) Inadequate Medicaid reimbursement is a public policy problem in connection with hospital reimbursement (and perhaps with large provider group reimbursement) because hospitals respond with a cost shift that results in health insurance premiums that are higher than they otherwise would be.

(11) Inadequate Medicaid reimbursement is a public policy problem in connection with physician and other health care provider reimbursement because providers who are inadequately compensated either may face financial difficulties operating a health care practice in Vermont, or may deny health care access to Medicaid beneficiaries. For example, many dentists restrict access to Medicaid beneficiaries. Furthermore, recruitment and retention of certain providers has become a serious problem in geographic areas or specialties with high Medicaid enrollment.

(12) Medicare reimbursement principles have been accepted by many as an appropriate standard that should be adopted for Medicaid reimbursement. Medicare reimbursement is reasonable because Vermont's federal allocation per patient is well below the national average, reflecting our relatively low-cost system, and the Congress has adopted mechanisms to insure that Medicare reimbursement is appropriate and fair. Establishing a Vermont-specific "reasonable cost" standard would require the development of a significant, new regulatory system to identify reasonable and appropriate costs, and to establish the level of payment needed to ensure access to services by Medicaid beneficiaries.

(13) Federal budget neutrality requirements imposed on the VHAP program constrain Vermont's ability to quickly eliminate the Medicaid cost shift, since VHAP program costs in excess of the budget neutrality standard will be ineligible for federal financial participation.

(14) Eliminating the Medicaid cost shift by reaching parity with the Medicare reimbursement standard would require substantial new Medicaid revenue: $12 to 19 million for Vermont hospitals; $4 to 6 million for Dartmouth Hitchcock; and $11 to 13 million for physicians.

(15) Most health care issues are inter-related; they cannot be solved in isolation. Eliminating the Medicaid cost shift is a goal that should be considered together with an integrated approach to other Medicaid issues such as establishing equitable Medicaid reimbursement policies, implementing effective cost containment strategies, and creating an adequate, equitable and economically efficient Medicaid financing system.

(16)(A) The state of Vermont shall adopt a fiscal strategy and appropriations to achieve the following goals:

(i) eliminate, within a period of time no longer than four years, cost shifting and under-reimbursement in the Medicaid program, with data developed by the joint fiscal office with the cooperation and assistance of the agency of human services;

(ii) reimburse health care providers in the Medicaid program at least at the federal Medicare level, or some other agreed-to payment structure to attempt to insure access and a stable delivery system; and

(iii) assure that Medicaid costs should continue to be consistent with Vermont's relatively low cost and efficient delivery system.

(B) To achieve the goals established in subdivision (A) of this subdivision (16) the state of Vermont should consider the following:

(i) A comprehensive strategy to align Medicaid program expenditures and revenues.

(ii) Progressively higher reimbursement levels until parity with the Medicare standard, where applicable, or some other equitable reimbursement standard is attained.

(iii) Monitoring the fiscal soundness and cost effectiveness of the program in consideration of effective utilization and quality programs, and greater federal flexibility in cost sharing and benefit plan design.

(iv) More equitable federal financial participation, by capitalizing on higher federal financial participation rates in other federal programs for existing VHAP beneficiaries, recognizing Vermont's high quality, low cost system as we approach universal access.

(v) A federal partnership to support pharmaceutical assistance programs, through greater cost sharing or a federal demonstration project.

(17)(A) On or before January 1 of each year until January 1, 2005, the secretary of human services, in consultation with, and with the cooperation of, the joint fiscal committee, shall recommend to the general assembly what steps need to be taken to achieve the commitment stated in subdivision (16) of this section to eliminate the Medicaid cost shift by January 1, 2005.

(B) The commissioner of banking, insurance, securities, and health care administration, the commissioner of personnel, each acute care hospital providing services to Vermont Medicaid beneficiaries, and health insurers, as defined in subdivision 9402(7) of Title 18 and as requested by the secretary, shall provide to the secretary such available information and reasonable assistance as is necessary for the secretary to make its recommendations as required by this subdivision.

(C) Sec. 117b of Act No. 152 of the 2000 Session of the General Assembly (Medicaid Cost Shift Reporting) is repealed.

Sec. 123b. 18 V.S.A. § 9456(b) and (c) are amended to read:

(b) In conjunction with budget reviews, the commissioner shall:

(1) review utilization information;

(2) consider the goals and recommendations of the health resource management plan or state health plan, whichever applies;

(3) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

(4) consider any reports from professional review organizations;

(5) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

(6) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

(7) give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets; *[~~and~~]*

(8) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;

(9) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid reimbursements resulting from appropriations designed to reduce the Medicaid cost shift; and

[~~(8)~~](10) seek the advice and recommendations of the public oversight commission.

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the health resource management plan or state health plan, whichever applies;

(2) take into consideration national, regional or instate peer group norms, according to indicators, ratios and statistics established by the commissioner;

(3) promote efficient and economic operation of the hospital; *[~~and~~]*

(4) reflect budget performances for prior years; and

(5) include a finding that the analysis provided in subdivision (b)(9) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers.

The 2002 General Assembly included the following amendments to the state budget requirements (this section was later amended to change references to "the department of prevention, assistance, transition and health access" to "the agency of human services"):

Sec. 148d. 32 V.S.A. § 307(d) is added to read:

(d) The governor's budget shall include his or her recommendations for an annual budget for Medicaid and all other health care assistance programs administered by the department of prevention, assistance, transition, and health access. The governor's proposed Medicaid budget shall include a proposed annual financial plan, and a proposed five-year financial plan, with the following information and analysis:

(1) anticipated revenues;

(2) anticipated expenditures, including anticipated per member per month expenditures for each population category eligible for health care assistance;

(3) anticipated caseloads, including anticipated caseloads for each population category eligible for health care assistance;

(4) anticipated utilization;

(5) health care inflation trends;

(6) recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement;

(7) recommendations relating to Medicaid and other program eligibility, the benefit plan, cost-sharing, utilization controls, reimbursement, and any other matter necessary to align anticipated expenditures and revenues; and

(8) any other recommendations or information affecting the financial sustainability of Medicaid and all other health care assistance programs administered by the department of prevention, assistance, transition, and health access.

Appendix G

Flow of Dollars from Hospitals to Commercial Plans

Note: This is a schematic of the hospital budget revenue increases and how some of the revenue increases are passed on to the Commercial insurance companies.